showing that an infection is still present, resumption of the milk diet should be delayed. When it is started, it should be given in small quantities diluted and preferably skimmed, and the return to the original strength should be made gradually. An excess of fat or sugar may cause diarrhea. Broths thickened with starchy substances or even thick porridges are of great value when the time for the return to food has come and the action of the milk is feared. In obstinate cases it is sometimes best to abandon the milk mixture and to use whey, casein milk, buttermilk, or the like. The thick gruels are very valuable as foods. On account of the starch, it is not advisable to continue their use over long periods. On account of the danger of relapse and recurrence restriction of the diet should be continued for the duration of hot weather. Gain of weight in these cases becomes of minor importance for the time. Acidosis is one of the great dangers during diarrhea.

OBSTETRICS

UNDER THE CHARGE OF

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The Prophylactic Forceps Operation.—DeLee (*Am. Jour. Obst.*, October, 1920, No. 1) contributes a paper in which he urges that many patients be delivered by the use of forceps without waiting for spontaneous expulsion. His method is as follows: When the pains are well established and cervix partly dilated, morphin-scopolamin are given and $\frac{1}{100}$ scopolamin given several times afterward. The patient's room is darkened and suggestion is employed. When the cervix does not dilate 15 grains of chloral and 40 grains sodium bromide are given by rectum, or gas and oxygen administered. It is important to obtain complete spontaneous dilatation of the cervix as slowly as possible; not only does the cervix dilate but the paracervical tissues retract which is most important and cannot be imitated by artificial means. When the head has left the cervix and rests between the levator and stretching the facia, ether is given to complete anesthesia and perineotomy is performed. The fetal heart sounds are carefully watched and forceps applied and patient delivered. Pituiglandol is often injected as the placenta passes out through the vulva, aseptic ergot is also injected if there is any hemorrhage. The operator waits five to ten minutes before delivering the placenta. If necessary the operator disinfects his gloves carefully and if the placenta is not visible inserts the left hand into the vagina and lower segment, palm up, while the uterus is pushed down on the placenta and the placenta then slides along the hand. If there is bleeding more pituitrin is given and $\frac{1}{4}$ grain of morphin and $\frac{1}{200}$ scopolamin is then administered to reduce the quantity of ether required for repair work, prolonging narcosis for many hours postpartum and abolish the memory of the labor as much

as possible. The cervix is then repaired and also the perineum and pelvic floor. The writer illustrates his conception of the anatomy of the parts and when this paper was presented, employed models to illustrate his idea. For this method the writer claims that it saves the woman the debilitating effects of suffering in the first stage and the physical labor of the second stage; but little blood is lost by this procedure. This method preserves the integrity of the pelvic floor and other tissues and prevents the results which follow lacerations. The brain of the child is protected from injury and from the effects of prolonged compression. In the hands of those not expert, this method might produce bad results. In a mother infected before labor complications might arise. The writer has had no mortality; mothers and children have done well. It is interesting to note that the method of version at the end of the first stage of labor proposed by Potter of Buffalo is condemned by the writer. He states while in Potter's hands the operation of version is safe, in less skilful hands very bad results will follow. In his mind, however, the same argument applies with less force to his recommendation of the operation of prophylactic forceps. This paper was presented before the American Gynecological Society and the majority of opinion was strongly against the adoption of this method in all cases and by all those who practise obstetrics. It was recognized as a procedure appropriate for experienced operators only.

Cranial and Intracranial Birth Injury.—Baily (*Am. Jour. Obst.*, October, 1920, No. 1) calls attention to the fact that a considerable proportion of stillbirths and early deaths are due to injury to the head of the child. In a few instances the prompt application of treatment might lower the mortality and morbidity. The mechanism of the injury has been described and illustrated. The veins of the cortex have little support as they enter the sinuses and hence pressure may readily rupture these vessels. In deformed pelves the head will mold unnaturally and undue pressure is inevitable. The posterior parietal bone may often produce severe injury. When the skull is fractured there is usually rupture of the meningeal vessels, although this condition seems to be rare probably because the dura is loosely attached to the bone in the newborn. A bad application of the forceps or excessive force might produce such a result. Bleeding from surfaces of the cortex is often retained beneath the pia and if near the cortical centers may produce considerable damage. Hemorrhage into one of the ventricles may occur from rupture of the choriplexus. The 40 cases proved by autopsy of cervical hemorrhage in infants, occurring at the Manhattan Maternity Hospital, are described in detail. Of these but 10 were not stillborn, 1 lived twenty minutes, another thirty, 1 three hours and others from fourteen hours to four days. But 2 of the children were delivered by forceps, 2 premature and 5 normal births. In the entire series 9 were forceps deliveries, 11 breech extraction, 5 preceded by version, 1 Cesarean case and 17 normal deliveries. The hemorrhage was diffuse in 18, especially marked under one bone in 11, diffuse, not in ventricle in 2, ventricle alone in 2, diffuse meningeal hemorrhage with thrombosis of the sinus in 1, 2 in the cerebellum, 2 in the pia mater, 2 in the dura mater. Five recent

cases of cranial and intracranial injury are reported in detail, three of them treated by operation with recovery and two dying without operation. In one of these a large osteoplastic flap was produced. In reviewing the literature of the subject it is found that results from decompression operations in infancy have not been really good. In some series the mortality has risen to 50 per cent. The raising of the depressed bone by piercing the bone with a sharp instrument and then pulling it up as recommended by Tweedy, is considered a makeshift.

American Journal of Obstetrics and Gynecology.—The publication so long issued by William Wood & Company, of New York, was by them discontinued some months previously. Obstetricians and gynecologists were not content, however, without a journal devoted exclusively to this branch of medicine. Dr. George W. Kosmak, editor of the *American Journal of Obstetrics*, with the assistance of others, formed an editorial board and the new journal was adopted as the official organ of the American Gynecological Association, American Association of Gynecologists and Obstetricians and Obstetrical Societies of New York, Philadelphia and Brooklyn. It is edited by Dr. George W. Kosmak, of New York, with Dr. Hugo Ehrenfest, of St. Louis, as associate editor. The publication of the journal was assumed by the C. V. Mosby Company of St. Louis. The first issue of the journal is printed on good paper with clear type and illustrations well produced. With the endorsement of American obstetricians and gynecologists and under the control of its able editor and editorial board this journal should have a most successful career.

The Function of the Corpus Luteum.—OCHSNER (*Surg., Gynec. and Obst.*, November, 1920) contributes further observations upon the function of the corpus luteum. He quotes the observations of veterinarians and describes 9 cases among human beings, where he has operated and removed the false corpus luteum. The health of the patient was greatly benefited and in many cases sterility was relieved. He quotes 2 cases illustrating the importance of avoiding, in operations, injury to the true corpus luteum. Observations seem to show that such injury is followed by abortion. His investigations indicate that an unabsorbed false corpus luteum prevents ovulation and is a common cause of sterility and that when such a false corpus luteum is removed by excision or expression menstruation occurs as a result. While this is true of the false corpus luteum if the true corpus luteum is excised or ruptured during the early months of pregnancy, abortion follows and this must be considered as one of the common causes of early abortion. It is interesting to note that injury to the true or false corpus luteum may simulate ruptured ectopic gestation.

Abdominal Pregnancy with Living Fetus.—MAURY (*Surg., Gynec. and Obst.*, November, 1920) has collected 29 cases of abdominal pregnancy in which the fetus was living at the time of operation. These occurred between 1909 and 1918. In 62+ per cent. the diagnosis was made before operation. In the whole number 73 were operated upon, 55 recovered and 18 died, a mortality of 24.6 per cent. There

has been but little improvement in the maternal mortality in recent years and in fatal cases death resulted from hemorrhage, sepsis or both; embolism, pneumonia and intestinal obstruction were also causes of death. The infant mortality was between 40 and 50 per cent. In a number of cases the child was deformed (usually some form of talipes), and the rate of deformity was about one-third of all the children. This did not seem to result in congenital cases, but from pressure to which the child's limbs were subjected in its unnatural position within the abdomen. About one-fourth of them gave history of premature rupture while the remainder had not been diagnosticated. A great majority suffered from pain in the abdomen which sometimes caused nausea and vomiting and frequently produced faintness and syncope. In about one-fourth of the cases irregular bleeding from the uterus had occurred and in one patient menstruation had been regular up to the time of operation. The placenta was usually attached to the pelvic organs, in 2 cases to the liver. In some there was a pedicle which could be ligated like the pedicle of a cyst. In some cases the tissue was so situated that the placenta could be removed together with the organ to which it was attached. Statistics show that if the placenta can be completely removed the mortality is very much less than where it is left or partially removed. There is no constant statement concerning the size of the uterus which seems to have varied greatly in different patients. As regards treatment these patients may be divided into three classes: (1) Those where the condition is not recognized and the patient goes into spurious labor with failure to deliver herself; (2) those where diagnosis is made but where the patient is so comfortable that she prefers to go on to as near term as possible without operation; (3) those who suffer so much from pain, faintness, hemorrhage or toxemia that they seek medical aid and should receive operation at once. While the first class are most numerous, as they do not often come to the physician, they are of less practical interest than the third. The majority of medical opinion favors operation in abdominal pregnancy if possible during the life of the fetus. It has been found that the further the woman is from term the greater are her chances of developing serious complications, the first half of pregnancy is more dangerous than the second. In those patients who are fairly comfortable, if they are seen before seven and a half months, operation should be done in the interest of the mother, if they are seen after that time, if they are in good condition and doing well and can be kept under observation, operation may be deferred until the death of the child. In each individual case the operator must decide whether he will remove the placenta or allow it to remain. Complete removal has given a maternal mortality of 10 per cent. while the mortality has risen to 40 per cent. in cases where the placenta was allowed to remain. The decision, however, cannot be based on statistics alone, but each case must be examined and determined upon its individual merits. When a pedicle can be ligated, the removal is simple. When the placenta grows from an organ which can readily be removed, this is also favorable, but when the placenta has developed on the liver or mesentery or is plastered on the wall of the pelvis, decision is difficult and there is great danger of hemorrhage at the time of operation or subsequently.